**MEDICARE PAYMENT ADVISORY COMMISSION**
**PUBLIC MEETING**
**Ronald Reagan Building, International Trade Center**
**Horizon Ballroom**
**1300 13th Street, N.W.**
**Washington, D.C.**
**Friday, March 11, 2005**
**9:02 a.m.**

**COMMISSIONERS PRESENT:**
Glenn M. Hackbarth, Chair
Robert D. Reischauer, Ph.D., Vice Chair
Sheila P. Burke
Francis J. Crosson, M.D.
Nancy-Ann Deparle
Arnold Milstein, M.D.
Ralph W. Muller
Alan R. Nelson, M.D.
Carol Raphael
William J. Scanlon, Ph.D.
David A. Smith
Ray A. Stowers, D.O.
Mary K. Wakefield, Ph.D.
Nicholas J. Wolter, M.D.

**AGENDA** PAGE


Medicare Part D: Geographic variation in drug spending 4
-- Rachel Schmidt
Medicare Advantage policy issues 17
-- Scott Harrison, Sarah Thomas, Dan Zabinski
Medicare Advantage Plans: Mandated report on payment areas and risk adjustment 84
-- Dan Zabinski
Medicare Part D: Grievances and appeals 127
-- Joan Sokolovsky
Medigap and cost-sharing: Before and after the Medicare Modernization Act 142
-- Jill Bernstein, Sarah Kwon
Mandated study on handling costs for drugs delivered in hospital outpatient departments 166
-- Chantal Worzala, Rachel Schmidt
Post acute care: how common are the patient assessment tools? 189
-- Carol Carter
Assessing the home health PPS 214
-- Sharon Cheng
Revising the SNF PPS RUG-III classification system 237
-- Kathryn Linehan
Public Comment 263
Panel on the use of clinical- and cost-effectiveness information by Medicare 268
-- Nancy Ray, David Eddy, Peter Neumann
Mandated report on critical access hospitals 353
-- Jeff Stensland
Improving outpatient dialysis payment policy 399
-- Nancy Ray
Public comment 426

**DR. STENSLAND:** Good morning. Today I'm going to talk about critical access hospitals and our mandated study. The Congress has mandated that MedPAC produce a report on the rural provisions of the MMA by December 2006. As an interim step we are also required to produce a report specifically on the critical access hospital provisions of the MMA by June 2005. In today's meeting I will review the current status of the CAH program, discuss how Medicare payments have increased to converting hospitals, present data on the improved financial performance of converting hospitals, and discuss some policy issues regarding the CAH 14 program. There are several restrictions on which hospitals can become CAHs but most are not binding. CAHs must have an average length of stay of four days or less. However, most CAHs have swing beds. The CAH can discharge Medicare patients to post-acute status. The same patient can stay in the same bed and generate the same Medicare reimbursement. CAHs must also be 35 miles by highway or 15 miles by secondary road or be declared a necessary provider by the state. Essentially, all small, rural hospitals have been designated as necessary providers. Therefore, the distance criteria is almost never binding. CAHs must be in rural areas. However, a state can declare any town rural for CAH purposes, even if it is in an MSA. Hence, about 10 percent of CAHs are in MSAs. Many of these are in fairly rural census tracts of the MSA. The binding constraint is that CAHs are limited to 25 beds. Because this is usually the only binding constraint, over two-thirds of the nation's general and surgical hospitals with under 1,900 admissions per year have converted to CAH status. Back in 2000 we had 139 CAHs, but the program has grown rapidly from 2000 to 2001 and to 2002, 2003, the beginning of 2004, and the end of 2004. At the start of 2005 we had approximately 1,070 CAHs. As you can see, some of these CAHs are in isolated rural areas of the country and some are fairly close to other CAHs. In addition, some CAHs are close to PPS hospital. The point being there's a great diversity amongst the different types of hospitals and their location in the CAH pool. This figure illustrates how close CAHs are to other hospitals. Most CAHs are between 15 and 25 miles from another hospital. However, we did identify 151 CAHs that are 15 or fewer road miles from the nearest hospital. Again, they become CAHs through that necessary provider provision I discussed earlier.

Why do hospitals convert to CAH status? Hospitals primarily convert to CAH status to increase their Medicare payment. Conversion tends to result in large increases in payments for outpatient services. Payments for outpatient services include payments for laboratory, therapy, and for physician being on call. For the on-call payments to be reimbursable, the providers must be within a 30-minute drive of the CAH, unless the CAH is in a frontier area, then the provider can be a 60-minute drive away.

Payments for post-acute care to patients in swing beds also increased substantially. But payments for inpatient services often do not increase substantially following conversion because acute care costs under CAH cost accounting are often close to prospective payment rates. We compared changes in outpatient payments for 498 hospitals that converted to CAH status between 1998 and 2002 with 551 similar hospitals that did not convert. The comparison hospitals were all located outside of core urban areas and had received 1,000 or 900 fewer discharges, which is the largest number of discharges for a CAH in 2003. From 1998 to 2003 we see that outpatient payments for certain services rose 69 percentage points faster at hospitals that converted to CAH status and received cost-based reimbursement. There are several potential reasons.

First, CAH Medicare payments were about $100,000 less than reported costs in 1998.
Second, CAHs received reimbursements for on-call payments located outside of the hospital. PPS hospitals don't.
Third, CAHs have lower incentives for cost control due to cost-based reimbursement., And fourth, CAHs may be increasing service offerings due to increased prices they receive for those services.

We will report further on how volume has changed at CAHs in our April meeting. I should note that the above figures may under-estimate the true growth in outpatient revenues because they exclude payments for laboratory and therapy services which were paid on a fee schedule in 1998.

**MR. HACKBARTH:** Jeff, could I just ask you a question about that? So these changes are a function of both unit cost growth and volume changes?

**DR. STENSLAND:** Right. So this is the overall effect and we're going to try to protect that down in April, in between volume effect and price effect.

**MR. HACKBARTH:** Bill has corrected me that these are the payments as opposed to any measure of cost.

**DR. SCANLON:** The reason I brought it up is because knowing the margin changes, it says a lot about what costs are doing.

**DR. STENSLAND:** Swing bed payments to CAHs -- for those of you who don't know, swing beds are beds in small, rural hospitals that can be used for acute care or post-acute care. These swing bed payments at CAHs rose to slightly over $1,000 a day. A 40 percent increase in swing bed days plus a roughly $700 increase in payments per day fueled the $463,000 increase in swing bed payments. Because CAH cost accounting allocates a large amount of cost to swing beds, the remaining costs allocated to acute beds are often not much more than PPS payments. Therefore, acute inpatient payments did not rise significantly following conversion.

Looking at this slide you may ask, what are CAHs' incentives to increase swing bed use? When a hospital has a swing bed patient stay one additional they will receive roughly $1,000 in additional revenue for that day. However, a swing bed day or any type of patient day results in spreading the hospital's fixed costs over more inpatient days. Hence, the expenses allocated to Medicare acute days will be reduced when Medicare swing days are increased. Accounting for this reduction in payments for existing Medicare acute patients, the net increase in Medicare payments for an additional post-acute swing bed day may only be $400 or $500 per swing bed day. This is approximately $100 to $200 more than SNFs receive for providing similar care.

This issue of reducing payments per Medicare day when patient days increase is most troubling when applied to charity care. The financial incentives to provide charity care at CAHs differ significantly from the financial incentives at traditional hospitals. When a charity care patient is treated by a traditional hospital, the hospital must absorb the marginal cost of treating that patient, primarily supplies and nursing time. When a charity care patient is admitted to a CAH, the hospital must first absorb the marginal cost of serving that patient, and second, absorb a reduction in Medicare reimbursement. The more charity care the CAH provides, the less Medicare pays. This is a troubling incentive inherent in cost-based reimbursement.

The slide presents an over-simplified example of how increased care for the uninsured reduces Medicare payment rates. First, assume a CAH has 1,995 inpatient days, that's acute and post-acute, of which 1,200 are Medicare days. If the hospital had $1 million in fixed, routine costs, the hospital would receive $601,534 from Medicare to recover routine costs. However, if the hospital admitted one more charity care patient who stayed for five days, the share of the $1 million allocated to Medicare patients would decline and Medicare payments to the CAH for routine costs would fall by $1,534. In this example, Medicare payments falls by roughly $300 for every day a charity care patient stays in the hospital. We do not know whether this incentive results in rural hospitals having slightly more restrictive charity care policies for non-emergency care. However, we can see 2 how this creates a strong incentive for CAHs to discharge charity care patients quickly and reduce the total number of uncompensated care days in the hospital.

CAHs have a tendency to expand services where they receive increased payments under cost-based reimbursements and drop services that are less profitable under cost-based reimbursement. For example, a University of Minnesota study found that CAHs are expanding imaging, laboratory, and rehabilitation services, all of which are cost based. We found that these same hospitals slightly

reduced their offerings of obstetric, SNF, and home health services. Offering these last three services would result in a hospital's overhead being allocated partially to these services and would cause a slight reduction in Medicare inpatient and outpatient payments to the hospital. The changes in service offerings at CAHs are consistent with their financial incentives. In total, payments for inpatient, outpatient, and swing bed services rose 47 percentage points faster at CAHs than comparison hospitals.

As we see on the following slide, the rapid growth in Medicare payments was accompanied by an increase in total profit margins. This is the real success of the CAH program on the slide. When we look at CAH financial performance we focus on all-payer margins for two reasons. First, we wanted to see if converters appeared to have better overall financial performance and a lower chance of closure. Second, changes in Medicare margins are difficult to interpret because conversions to CAH status results in a change in cost accounting rules. If we looked at Medicare margins it would not be clear the extent to which a change in Medicare margins is due to a change in cost accounting or to a change in actual financial performance.

Prior to conversion, many critical access hospitals were facing low volumes, high costs, and low margins. Following conversion, Medicare payments and profit margins increased substantially. With improved profit margins, closures have almost ceased. We are only aware of one closure in 2004 and a for-profit entity is considering reopening that CAH. We can conclude that the CAH program has been largely successful in achieving its mission of keeping rural hospitals open.

However, some of the hospitals the program is keeping open may not be critical for patients' access to care. The 2003, CAHs received approximately $2 billion of cost-based payments; 17 percent of those payments went to hospitals located 15 or fewer miles from another provider. Fifteen percent of payments went to hospitals more than 35 miles from another provider. In 2005, we expect cost-based payments to CAHs to be approximately $4 billion. Cost-based payments to CAHs are expected to roughly double, primarily due to an increase in CAHs, but also due to an anticipation of increased costs per CAH. Payments per CAH have historically risen by more than 10 percent per year. Spending additional Medicare dollars to keep small hospitals open when they are more than 35 miles from the nearest alternative source of care is relatively uncontroversial. Keeping hospitals open that are 15 or 17 fewer miles from another hospital is a more difficult decision. If quality improves with volume, then merging small hospitals that are close to one another may be beneficial. The key question is whether the benefits of increased volume and cost savings outweigh the burden of additional travel time for beneficiaries.

In our April meeting we will discuss the quality of care and patient volumes at CAHs. Starting in 2006, the MMA requires that states will no longer be able to declare to new CAHs necessary 5 providers. However, the 151 hospitals that are less than 15miles from another hospital will be grandfathered in as CAHs. The Commission may want to consider whether having low volume providers close to one another is the best way to care for Medicare beneficiaries, and whether CAHs should be 15 miles from all other providers.

The Commission may also want to discuss changes in the payment for post-acute patients is swing beds. A typical CAH will receive a net payment of $100 to $300 more per swing bed day for post-acute patients than local SNFs receive for post-acute care. Twenty-eight percent of CAHs themselves have a distinct part SNF. Hence, payments for two patients receiving identical care in the same building may differ. Medicare may be $300 for one more SNF patient day and pay $450 for one more swing bed patient day. An alternative to cost-based payments for post-acute care patients is to pay CAHs the same rate that is paid to local SNFs. However, this would result in a reduction to CAHs payments from Medicare.

A third issue to discuss is the profit margin provided to CAHs. Currently, CAHs receive 100 percent of allowable Medicare costs. As costs go up, their Medicare profits go up. This can create an

incentive to have a highly leveraged facility, as was the case with SNFs when they received cost-based reimbursement. An alternative to paying hospitals a 1 percent return on their costs would be to pay hospital's return on the equity in their physical assets; physical assets minus liabilities. Under this system, when members of the community make donations to their CAH and the hospital therefore reduces its debt it would not have a reduction in Medicare payment rates. The rate of return on equity could be set so that average payments to CAHs do not changed but incentives would improve.

One way to avoid the problems with cost-based reimbursements is to provide CAHs with a single, lump sum payment. Hospitals with under 25 beds that are more than 15 miles from another provider could to be given a fixed payment. For example, $500,000 per year, plus the prospective statements given other hospitals. The fixed payments would help defray the cost of providing standby emergency room service in a low population density market. If our objective is to retain access to emergency room services, we could pay directly for standby emergency department capacity. There are several advantages to this approach.

First, CAHs would have stronger incentives to control costs.
Second, providing charity care would no longer cause Medicare payments to decline.
Third, Medicare revenue would be less volatile because it's tied less to patient volume.
Fourth, it would provide rural communities with more flexibility in how they want to structure their local health care system and the relationships with nearby facilities. They would no longer need to retain high volumes in services, such as imaging or swing beds, to cross-subsidize the emergency department.

So to summarize, I think we have at least four discussion topics which I'd like to hear your thoughts on.
The first is requiring all CAHs to be 15 miles from other hospitals.
The second is setting post-acute care rates for CAHs equal to those of local SNFs.
The third is paying a return on equity rather than a return on cost. and,
The fourth is a change to a fixed subsidy rather than cost-based reimbursement. 3
Thank you.

**MR. HACKBARTH:** Jeff, let me ask a question related, I think, to the first one. To the extent that we have more CAHs and that they serve more patients, is there not an impact on the non-CAH hospitals that are close to them, many of which are small themselves? So assume for a second that there's a finite pool of patients, and if we're shoring up the CAHs, that means there are fewer patients that might go to the rural hospital in a little bit larger town, thus reducing its volume, its ability to add programs, or its financial well-being. Is there any way to get at that impact on the adjacent hospitals?

**DR. STENSLAND:** I'll have to think about a way to get at that, but that certainly is an issue. For example, when HUD considers making loans to CAHs, one thing they do is they go talk to the other hospitals around that CAH and ask out that CAH affects their business, and whether there's duplicative capacity. And in some cases they decide there is duplicative capacity so we're not going to make a loan to that facility because we think it would harm the nearby facility. Then there's also the volume issue and quality.

**DR. WAKEFIELD:** With regard to the subsidy discussion, I just have to say that I mentioned to Ralph right before we got into this, just before we started this formal discussion, that if we're talking subsidies perhaps that GME subsidy that he's always so fond of could be -- we could be looking at orders of magnitude for this subsidy for CAHs. He then responded that he's really quite pleased that I'm leaving the Commission this year. I'm trying hard not to take that personally. 11
[Laughter.].

**DR. WAKEFIELD:** Just a few comments and I'll get you the rest of my comments because there's not enough time and everyone will become nervous that I'll wax on and they'll miss their flights, so I won't do that. But I do want to make a couple of comments about tone, first, of the chapter, because I think that predisposes at least me to a certain view about the information that's presented. And secondly, a few comments on some of the data from the research you've conducted and maybe some ideas about things to think about as you continue with the next presentation or the presentation that we'll have in April and the work that will have to underlie that.

I also want to say on the front end that you ought not construe my remarks as being supportive of this program exactly the way it currently exists, and that it in fact supports every single CAH out there as being a well-documented essential provider. I think like anything else there's obviously room for aligning the intent of the program with the way the payment policies are structured, and certainly there's room for improvement with this as there is with everything else. So I don't want you to think that this is just -- I'm hunkering down here and suggesting it ought to stay just the way it is. That's not what I'm saying.

On the other hand, the flip side of that for me is, let's make sure that when there are changes that are made that the brush is not so broad that we do collateral damage to what was the intent of this particular program, which was to assure access, essential access to what could otherwise be construed as a pretty vulnerable population, that is Medicare beneficiaries. We already know that they are not the ones who tend to travel down the interstate to go get care 80 miles away, if they can avoid it. The 22 year-olds in rural areas do, but the 75-year-olds don't necessarily. So that's the balance that I think we need to be thinking about achieving, aligning it but being careful not to do damage to access, which is the original intent of the program.

With that let me just make a couple of comments about tone, as I said, and then reference some of the content in the document that we received, and then also some comments about the findings. In terms of issues that were presented, first of all, in the chapter we talk about the MMA sunsetting governor's authority to designate small, rural providers as necessary providers. On page 4 we state that state officials can increase the flow of Medicare dollars into their states by declaring more hospitals necessary rural providers, so they have declared essentially all of them in order to maximize that Medicare flow.

I think the outcome is probably just the same, the response is the same, but I don't know that that stimulus is actually accurate. Obviously, that happened with the Medicaid program in some states, but I have never heard of that as the rationale, that is boatloads of federal Medicare dollars coming into states, as the rationale for designation. I do think that there probably is political pressure teed up and governors probably had to deal with that, so I'd say that might be fair in some cases. But your rationale here doesn't mean a whole lot perhaps, but it's just nothing that I've ever been privy to.

Also, I'd say that the simple fact is that with BBA '97 states were allowed to establish the rural hospital flexibility program and within that critical access hospital status. The states had to apply to then-HCFA in order to achieve that designation. So there were application criteria that HCFA imposed. It wasn't just governors designating it and it was done. In fact there was a process that had to be followed for designation; the designation of necessary providers, and that those necessary providers had to be part of a broader rural health plan. So that was a document and an application process that was in place. CMS allowed fairly loose, some would say, necessary provider criteria, and once you open that wide then other hospitals followed suit.

So I'm just suggesting that here the tone is, bad things are going on out in the states, and I would suggest that perhaps some of what created more CAHs to be designated than what might actually make sense in terms of the intent of the program could well have been the fact that we didn't have terribly tight criteria on the front end against which plans would be reviewed. Also, states don't redesignate urban hospitals as rural hospitals. As application process has to be made to CMS. They

can't just say, you're rural, and suddenly for Medicare purposes it's rural. So we can talk about the states' role, but I think we also ought to be talking about CMS, because in fact maybe some of the solutions to some of these issues may rest there too, may rest with CMS. Not just with what we're doing out on the frontlines with the states.

**MR. HACKBARTH:** Mary, could I ask about that so I'm sure I understand it? The way the law was written, was CMS granted the discretion to say, we don't like the state's plan so we won't accept the designations? Or was CMS's review strictly procedural, so long as the appropriate steps were followed the discretion was the governors?

**DR. STENSLAND:** When I talked to the people at CMS, that was their impression, they didn't have a lot of discretion to say no. I think this is actually something we can actually quantify if we need to because when you look at the whole issue, we start out with there's maybe 1,500 small hospitals in the country with 1,900 or fewer discharges, and about 100 of those are in real core urban areas. Many of those are physician-owned specialty hospitals like spine hospitals and that kind of thing. So if we throw those out we have about 1,400 left. Out of that 1,400 we have about 1,100 have converted already, so we know those were eligible to convert. Then there's only about 300 left. So we could even, if we wanted to, we could go through those and see if there is five or 10 that weren't eligible. But it's going to be the vast majority of that 300 that's left over.

**DR. WAKEFIELD:** To your question, I don't know the exact answer. I think worth pitching. Clearly in the field, I can tell you, that the sense was that there was an approval process that was put in place and that it wasn't an automatic; you submit the data and it gets checked off and rolls through CMS. But I can't say that with certainty so it would be worth going back and finding out. The other part of that and why I make the point is to say, as we look for solutions we might also be looking there in terms of future review processes. If there's a reason to tighten things up that might be a place to try to leverage appropriate criteria, if you will.

**MR. HACKBARTH:** Let's just try to nail that down, who was vested with the discretion here, whether it was CMS or the governors.

**DR. REISCHAUER:** We can also look at the number that were sent to CMS and the number that got designated. There's different dimensions to this. One of the criterion might have been interest in winning the state in the next election.

**DR. WAKEFIELD:** Not that that would ever happen. But the point is, at least from my perspective, perception was criteria were really quite broad. Yes, there were criteria. Criteria had to be met. Criteria were quite broad. How that really played out you'd probably have to go back and find out.

Just another comment on the mileage issue, the zero to 15, 15 to 25, 25 and higher, et cetera, and your good parsing of the hospitals that fit within those categories. It might be more than what we'd want to do but since you've got two bites at this apple -- I hate to say it, but 15 miles or 20 miles isn't always 20 miles, isn't always 20 miles. I do a lot of work with designations on mileage and minutes to health care facilities because it's so critical. Where I sit right here I might be able to get to two different hospitals within 10 minutes as I sit right here. But as I sit in a mountainous area of the state of Virginia, that 20 miles might translate to something quite different in terms of time. So I'll just tell you that out in a different arena there's a lot of work being done about what access really means. Mileage is a proxy but as we're carving these into categories I think that there's some finer tuning that probably could be done there.

At least you might want to try to look at anyway, instead of just these firm designations, because I don't think they mean what on the face you might think they always mean. Which isn't to say that in that zero to five miles and you've got two hospitals, that those are legitimate in terms of the 19

intent of this program. I want to make that point. But I don't know that it's as black and white as it's listed here

A couple of other issues. On footnote two we say that hospitals can always discharge their patients to swing bed status and receive the cost-based payment holding the same patient in the same bed. First of all, that statement implies, I think, that the hospital is making the decision when in fact it's probably the physician who's making the decision, and in fact there are swing bed criteria, clinical criteria about moving a patient out of a hospital bed and into a swing bed, and a physician makes that decision. Hospitals can get nasty letters about quality, and physicians can get nasty letters too if those criteria aren't followed. Now you might argue the criteria, but it is just to say that that footnote suggests something little bit more than what I think is actually the case.

Next on page six you talk about before hospitals deciding whether to convert to CAH status they almost always have a consultant or an accounting firm to estimate whether their Medicare payments will increase. True enough. In fact the flex program actually funds some of that activity. I think that's just good business. I think that Ralph's shop probably has a good CFO that can run the numbers and maybe for people who work with him or her. That's not the case in a lot of these little critical access hospitals.

The CEO might be the same person who's out there shoveling snow in the front of the building, it might also be the one with pencil and eraser trying to figure out impact. So in fact the feds deliberately tried to wrap around some support through the broader flex program to support sound business decisions being made. I'd say that if you've got a sentence like that and the tone that it implies; i.e., gamesmanship, you might as well be tossing it into just about everything that we write because any time there's a switch in payment people ought to be doing exactly this. Now where they take it to might be a different story. But that's what I mean about tone.

On page 13, some personal communication from Charles Davis at HUD. Again we're saying that they declined, and you made the comment a little bit earlier, several potential applicants to the HUD 242 loan program. But I can't tell from that if that was seven applications or 17 applications or 70 applications. But where that language leads me is to think, we've got a significant problem here; potentially it could lead me there. So that's what I'm talking about when I'm referencing tone.

Likewise, the comment about radiology services and the expansion. Again, true enough. Certainly there is and has been an investment in technology. I think perhaps a worst case scenario would be an MRI, and there are CAHs, as you point out, that have made that particular purchase. So if we're trying to illustrate the extreme, you've done that. If we're trying to illustrate what is this investment in, and you can have different opinions about that, the investment is more likely to be in CT scans, for example, with MRIs really being truly the extreme.

Also profit margins at the hospitals having increased substantially. I think maybe a little bit more word about how to interpret that -- and I know you'll be building that into the report -- would be helpful. It's profit margins moving from what to what? If we're moving from a negative 16 percent margin to a plus 2 percent margin, that's a pretty substantial increase. That may not be all bad, pulling them up out of negative and into a low positive, for example. So some of that kind of explicit information might be useful too.

Last point that I'll make about tone. There's a discussion of the proposal to provide fixed payments to reduce CAHs' current disincentive that you talked about to indigent and Medicaid patients. While there might be some CAHs out there that are closing their doors to those categories of patients, I can tell you I have never heard that. I've never heard CAH CEOs talking about the problem with that, and I've never heard them even alluding to the fact that that's really a budget buster for us and we're not going to go there. So I would say if you put that in as rationale for a new payment methodology

we might try to figure out where that's happening, to what extent that's happening, and so on, because we're writing that in as part of the rationale and that just doesn't gibe with what I've seen.

You might also think a little bit about DSH payments then for CAHs as a way to address -- if you redo the formula as MedPAC has suggested and then think about DSH for CAHs as a more direct way of dealing with some of those issues. That's probably enough on tone.

I'll just make a couple of comments on methodology and then I'll let other people talk. One, I'm wondering, I guess, what we might learn if our two groups, the converters and the non-converters, were compared on Medicare allowable costs; costs to costs rather than payment to costs, and what might that tell us about the nature of those two groups and what's going on with them. Right now it's a little bit apples to oranges. I understand why you're trying to do that, I think. But there's also an apples to apples comparison that might be informative to look at too. Secondly, there is a fairly significant difference in the converters and non-converters, I think, on the inpatient revenue side, almost twice as much, about $2.4 million, I think, versus $1.2 million on inpatient, I think. That might also suggest that there are some important differences to look at between those two comparison groups too. I don't know, but if you drill down there a little bit more, if I'm not wrong about that, that might be worth looking at.

On page eight, table two you've got a column there that talks -- this is the table that talks about CAHs benefitting from large increases in outpatient and swing bed revenues. You've got a column there that talks about total Medicare inpatient, outpatient, and swing bed payments after the CAH conversion. That's where I think you're drawing the $850,000 more that CAHs have received in payments than their comparison hospitals. I'm wondering though if you could also tee up a little bit of rhetoric around the next column which speaks to change, and that difference is $505,000 between the two categories, not $850,000. So what does that tell us, and is it worth explicating that smaller difference as well? Something to think about.

On page 17 there's a discussion of profits and the fact that CAHs receive 101 percent of Medicare allowable costs, a 1 percent profit margin. You might want to put in there maybe, or in some way that's cleaner and more precise than this, what that 1 percent amounts to. We estimate here that there are about 1,055 CAHs and that computes to just under about $3.8 million per CAH, I think, and 1 percent of that then would be about $38,000 each. The $38,000 associated with that 1 percent is probably going to buy you, if you're lucky, a nurse in terms of benefits and wages. So we're not talking big dollars there. That's sort of a real rough cut, but it's to try to help the reader get some sense of magnitude, order of magnitude here in terms of what's actually occurring there I think.

The last comment I'll make -- I've got more pages but I'll -- you're happy now that I'm suggesting I'll just send them to them by e-mail. Just a couple of other -- one more comment or two. The ER on-call doctor issue gets some play in the text. But I'd say, keep in mind that CAH costs for an on- call doctor are significantly less than if they're paying that physician to be there for 24 hours a day on site, and the cost center is the emergency room, which is typically not a big -- it's not used heavily typically in most CAHs by Medicare beneficiaries. Maybe about 20 to 30 percent. You can verify that. But in some cases, I will tell you, significantly less than that. That's not just where those patients typically tend to come through. So that Medicare utilization is probably pretty low. What does that mean in terms of real dollars to the Medicare program? Say a CAH pays $250 per night for one of its physicians to take calls 365 days a year? The allowable cost might be just over about $91,000 for that on- call doctor. Thirty percent reimbursement of that is about $27,000. So again we're focusing attention on something, but in terms of total dollars there aren't big dollars. You raise the issue, but I think we need to give order of magnitude to it as well.

I guess I'll stop there and maybe reserve the right to come back in if it's okay.

**MR. HACKBARTH:** You've got a lot of important information there, and I know Ray has got a lot of things to say on this as well. What I'd ask each of you to help us with is ways that the program can be improved and better targeted. I accept the premise which is, as I understand it, that there are certain institutions that are necessary to provide access to people in remote areas. A fear that I have when I look at those maps and the series of red dots spreading across the country and many areas of the country is that the basic purpose is being lost sight of, and ultimately that threatens the program, it doesn't strengthen it. At some point it just loses credibility because it's so detached from its original mission. So if you can help us say, here are ways that we can achieve that mission, which is a critical mission, and refine the rules, better target them, that would be extremely helpful.

**DR. WAKEFIELD: I**f I could just add on that point, I'd strongly suggest, and actually I mentioned this to Jeff, a few people I think he could also talk with, now that you've got the data to run this by, who might have some ideas besides us. MedPAC staff have accessed panels of individuals before -- not to come and talk to us, but where they've accessed panels of individuals before to get some input and reaction to data. I think that's critically important. I've given you names. I'd also deal in that mix, Office of Rural Health Policy. They certainly have a couple of people over there who are really expert in this program, and you'd have a different fed agency perspective about potential changes to the program too.

**DR. STOWERS:** First I'd like to repeat everything that Mary said.

**DR. REISCHAUER:** But slower.

[Laughter.] 17

**DR. STOWERS: I** really will try to cut to the quick here but I've got a few points I think are -- one on the political pressure thing. On this political pressure, I think we've got to be real careful where we go on this, that a town of 2,000 people is going to swing a governor when they're down the road from 50,000 or 100,000 votes for a particular thing. I think the general consensus here is everybody does not want these hospitals to close, and generally there's very little opposition from neighboring 4 hospitals, and if there is, they don't tend to go down that path. So I think we've got to be real careful because politics is votes, and there's not a lot of votes in a lot of these small communities, so we've got to be real careful on that one.

I have to really add just a tiny bit to this thing on the government push on this thing. We tend to look at them like they're going out and playing the system and doing that kind of thing. But the flex grant is, just so you're aware, literally mandated the state offices of rural health to go out and do consults and offer this program to every single eligible program out there. The consults were paid for by federal dollars. The consults also were mandated that the decision to go PPS or stay PPS or go to cost-based had to also be based on bringing that hospital up to current efficiencies. If there were behind in accounts receivable or other managerial problems, that had to be taken into account before they would get the green light to go on to do that kind of thing. All of this was mandated, and money from Congress to push the conversion and that kind of thing. So I think that atmosphere, I agree with Mary, needs to come across in this chapter, the concerted effort that came out of HRSA and the Office of Rural Health and all that kind of thing, to do that

I won't belabor this either, and this was really, I think, a significant thing that we need to change in the chapter, at least look at, and that's this idea of net increase. We've admitted in the chapter that there's not much increase in the inpatient and payments and that kind of thing. But even when we talk the outpatient we tend to talk total dollars that have changed in outpatient here, but I like Glenn's idea because I think it's very true, there's kind of a fixed amount of patients out there and a fixed amount of outpatient work that basically needs to be done.

It may be more of a shift of location, where it's being done. As one of your slides showed, there's an increase in laboratory, increase in x-ray that's now accessible to these rural communities. It would be natural that their volume would go up because now people are not having to drive 15, 20, 30 miles to get their x-ray done, or even their CT done.

I'm not personally aware, although there may be one or two in the country that have an MRI like she said, but several have managed to get up to the level of being able to have a CT. So I would expect the outpatient to go up. It's also attracted a lot of physicians into these critical access hospitals who are more specializes, because now they can afford an outpatient suite to do outpatient, so there's a lot more GI doctors that are traveling out to do these services one day a week or that kind of thing in the rural hospitals.

So I'm not so much worried about how much more money is shifting out into these rural communities. I saw that as a goal of the program as much, as what the total increase in outpatient services has been to the program, because that's what we ought to be looking at here is increased cost to Medicare for doing this.

I agree with the order of magnitude thing here. We've had 1,100 hospitals convert and we talk total dollars, but the cost per hospital here -- this volume is huge, but in the other case we need to look at that.

Another thing that came out in your slides, I think it was page 13, on there where we -- I'll wrap this up, Glenn -- and I do have some thoughts on what you were talking about. When we talk about the total amount of payments for hospitals, the programs came on because we had literally hundreds of hospitals in the country being threatened to close. I'm not so much worried about the percentage in increase in these hospitals, but now where we stand in comparison to their comparison hospitals. We get down to where there's very little difference now, even though there's been a big percent increase. That was the purpose of the program. But again, the net cost to the program as we go on in the future is the difference between in the $1.06 million and the $1.038 million, and it's the ongoing cost to have this access available that I think we ought to be looking at, not the increase that's occurred over the implementation of the program.

There's like 1,400 in the nation that totally quality and we've already got 1,100 of them, so there's only 300 potentially out there. The vast majority of them have had this consult done by the feds and have been told they're better off to say -- so there needs to be some magnitude in here of how many still potentially would do better with cost reimbursement. I would estimate that that is a very small number because almost everyone has been through this consult process by this time, and have been told with efficiencies they're better to stay in the PPS.

I can't go without saying that I think this charity reach is really a reach. They're the only hospital in the community. I think the cost reimbursement has allowed them to do more charity care. But to say that because there's the potential out there that they might have a cut -- I think we need a lot more solid data before we would ever -- that they really have stinted on charity care in their communities.

The HUD program, by the way, we have one of the only two hospitals that have been approved and recently constructed under the HUD program, and it's within very close, probably a little too close proximity to a neighboring hospital. The neighboring hospital was in full support and became their sponsor hospital. So we've got to be careful on this HUD statement. There's only been two in the nation that have opened under the HUD program, so I agree with the magnitude thing there, that we need to be careful with that kind of thing.

Glenn, I totally agree with you and with Mary that we need to look at the system and be careful, and I think probably the one main issue is this distance, that has gone through the governmental process. I would contend that the 35 miles is way too far. I know it was an arbitrary number in the

beginning. I practiced with one 17 miles north of me, and the other hospital that we went to every day was almost 40. When you have somebody having a heart attack or an acute anaphylactic reaction or that kind of thing, by the time you load them, transport them and that kind of thing 9 miles can be a very long distance. My daughter had an acute allergic reaction with near anaphylaxis in Tulsa. Would have been in a small town five years ago. Ended up being transported to a major medical center. Waited 45 minutes in the emergency room. Had to go through extensive recovery from that. I'm only getting around to the thing you're coming to next month and that's going to be talking quality. I can guarantee you in the small hospital, the adrenaline and that kind of thing would have been given immediately, and that the care would have probably been more expedited and better.

The only caution I'm putting there is that the data out there on quality in these hospitals, for what they do, is somewhat preliminary, but it's showing for what they do it may even be better, and it's probably not a lot volume related in that. And that the centers of excellence type volume is better type principles will not probably apply here. So I'm just giving some thoughts and word of caution on that.

Glenn, I think, again, that probably tightening up the process somewhat on distance and being sure there's consensus from the hospitals around and that kind of thing are going to be a good thing. I've got a lot of other things too but I think we've just got to be real careful with the tone of this chapter.

**DR. WOLTER:** Just a little background -- maybe it's disclosure. My organization actually manages seven critical access hospitals, six of them are in southern Montana and one in northern Wyoming, and in a couple of all those communities we also employ physicians. In Montana, which as the chapter said, pioneered the program, of I think about 53 hospitals in the state, 41 are now a critical access hospital. I think only three of them would be affected by tightening up the 15-mile rule, although they would strongly argue their case, I would think.

A couple comments. I would agree, I did think the tone was a bit overly negative, and the charity care, I can just tell you, is certainly not in play in anything I've ever observed. In fact these are not-for-profit community- governed organizations. There's a huge commitment to that in a state that has 21 percent of the population uninsured. That one is really a stretch in terms of what it might be implying.

In terms of the consulting dollars, my organization would consult hundreds of thousands of dollars more annually than the critical access hospitals are able to. They really struggle. They don't have the infrastructure in terms of resources to do facility planning, human resources, billing, and accounting, consulting. I think that's really one of the issues that they face.

As far as the big increase in outpatient payment, our analysis of that would be, that was where the problem was. Because under PPS, critical access hospitals more or less made it on the inpatient side, at least those that I have experience with. But where they really struggled was in the outpatient arena. So the cost plus 1 percent has filled a gap that was really the problem that I think existed. So I would take that information and make sure it's in an appropriate context.

As far as the new service development and services dropped, of our seven hospitals, four of them often OB and two have dropped it. They dropped it having nothing to do with critical access versus PPH, but they would do 30, 35 deliveries a year, very low volume, and anesthesia costs be $200,000, $250,000 a year to try to cover that low volume, and it just wasn't sustainable to stay in that business line, especially with some of the advances. So those were very difficult decisions, I might add, and created a lot of community consternation, but those decisions were made.

As far as moving into other services, I think there are some similar impulses in these communities that we see in large urban communities. For example, imaging. Traditionally, the DRGs coming

through a small rural facility are those DRGs where there is either very minimal profit or there's a negative. As we have seen in the DRG system, there's the universe where there's a margin and there's the universe where there isn't, and they live in the universe where there's not cardiac surgery, orthopedics, and neurosurgery. So it would be natural for them to look at services that might make sense in their community where there would be profit. Certainly, imaging is one of those, and we have had a couple of our communities and move into CT scanning. There's a clinical reason for that too. With the advent of pacts, when there's trauma, having a CT reviewed seconds later by a radiologist in a larger community 50 miles away can make a huge difference to patient outcome. So I think there's some common sense to some of the trends we're seeing. It isn't all about finances, although certainly some of it would be.

On swing beds, it would be fair, I think, for us to acknowledge that one of the underlying issues on that thinking is SNF payment. Hospital-based SNF payment, especially in low volume critical access SNFs, it's a losing proposition. Although we are quick to throw out hospital accounting practices as the reason, I can tell you that's not it. It is that you lose money on the SNF side, so the swing bed is at least a place to try to get yourself back to something that's a little bit more reasonable. So we should 21acknowledge, I think, all sides to this conversation.

As far as return on equity as a possibility, I don't know how that would work. In our experience, we have mostly low debt facilities now, but they are not very high equity facilities because they are 40 and 50-years-old. They haven't had the dollars to invest in new infrastructure. They in many cases are grandfathered around many code violations. They don't have the dollars to put new technology and information systems in place. And certainly even the cost plus 1 percent isn't correcting 9 that. Many of the facilities haven't even been able to fund depreciation in recent years. With the experience Montana has had, and of course we were early on in this, we've gone from -- this would be all the critical access hospitals across the state -- from the group averaging net negative margins to 2003 there was a positive 0.19 percent margin. I think that's a total margin or an all-payer margin, rather, not just a Medicare margin.

Then on cost control, I see a lot of incentives in our facilities to manage their costs aggressively because they're still so at the margin in terms of their overall bottom line. It's not like they are seeing opportunities to really pad anything. So at least I see a lot of cost control activities.

Glenn, I would certainly agree with your thesis, we need to be very careful that what transpires doesn't endanger the original mission of this, but I do want to be careful that we have the right tone and information about where this program really, I think, is succeeding. So those would be my comments.

**MR. HACKBARTH:** We are well over time. Any urgent final comments from anyone?

**DR. SCANLON:** Normally, I think I would want to look at this in terms of these hospitals compared to some group and see how they're faring, and I think the problem is that we don't really have a very good comparison. Given that distance is going to be, I think, a critical part of our thinking, it would be helpful if we could do some of these tabulations by the distance to the other hospital, to know what group we might be affecting by looking at a recommendation with respect to distance.

**MS. BURKE:** Just one cautionary note, and it's one that Mary raised. I will take some blame here having been involved in some of this originally. Certainly, in the swing bed creation and in some of the issues of treatment for rural hospitals. A mile is not a mile, and I would only raise the cautionary note that we be careful about using absolutes. It is certainly something that ought to be considered. It certainly does raise some appropriate questions. I'm just like Glenn, I worry about the behavior of some putting at risk what was a fundamental commitment that I think still makes sense. But I think that we ought to be very careful, and the Office of Rural Health is a place where we can go to understand in fact what the reality is here. In mountain states and states with horrific weather

patterns, there are real issues that need to be considered that differ depending on the time of the year and the location. I would agree with you that is an easy way to start that analysis but I would just caution that we need to look very carefully at what that mile actually means in all 16 cases.

**DR. STOWERS:** A final word. I would just like my final word to be a question, and that I think the chapter needs to make very clear. That is, if I have two critical access hospitals that are 14 miles apart and I close one of them and now all of the people travel to other communities 30, 40 miles away, how have I saved Medicare or CMS any money by closing that hospital?

So we're worried about numbers here and even distances, but if two hospitals are getting along and they're 12 miles apart, and we're talking saving costs to CMS here, how have I reduced cost to CMS by having those people from that community lose their hospital and economic base and all of that and go to town B? Where's the savings? I think that's where I'm a little confused, where our objectives are here. I'm just throwing that out. And what would the net savings be of closing that hospital to CMS?

**DR. REISCHAUER:** I can give you an answer to that, although I'm very sympathetic to the points that have been made. The answer is, some of those people would go to a PPS hospital. But it's a fraction of 100 percent.

**MR. HACKBARTH:** Thank you, Jeff.